Attachment B-1

Date: 9/1/87

FORM APPROVED
OMB NO. 0938-0008

Audiology Services

HEALTH INSURANCE CLAIM FORM

(CHECK APPLICABLE PROGRAM BLOCK BELOW)

[ ] MEDICARE (MEDICARE NO.) [X] MEDICAID (MEDICAID NO.) [ ] CHAMPUS (SPONSOR'S SSN) [ ] CHAMPVA (VA FILE NO.) [ ] FECA BLACK LUNG (SSN) [ ] OTHER (CERTIFICATE SSN)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): Recipient Im A.
2. PATIENT'S DATE OF BIRTH: MM DD YY
3. INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): Same
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow, Anytown WI 53725
   TELEPHONE NO.
5. PATIENT'S SEX: MALE [ ] FEMALE [X]
6. INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE, INCLUDE ALL LETTERS): 1234567890
7. PATIENT'S RELATIONSHIP TO INSURED: SELF [X] SPOUSE [ ] CHILD [ ] OTHER [ ]
8. INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.)
   [ ] INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN
9. OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER): OI - C
10. WAS CONDITION RELATED TO:
    A. PATIENT'S EMPLOYMENT: YES [ ] NO [X]
    B. ACCIDENT: AUTO [ ] OTHER [ ]
11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
    TELEPHONE NO.
11a. CHAMPUS SPONSOR'S STATUS: [ ] ACTIVE DUTY [ ] DECEASED [ ] RETIRED — BRANCH OF SERVICE
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING) I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW
    SIGNED / DATE / / / / / / / /
13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW
    SIGNED (INSURED OR AUTHORIZED PERSON) / / / / / / / /

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF ◄ ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
15. DATE FIRST CONSULTED YOU FOR THIS CONDITION
16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY GIVE DATES / / / / / / / / / / /
16a. IF EMERGENCY CHECK HERE [ ]
17. DATE PATIENT ABLE TO RETURN TO WORK / / / / / / /
18. DATES OF TOTAL DISABILITY FROM / / / / / / / / / THROUGH / / / / / / / / / / /
    DATES OF PARTIAL DISABILITY FROM / / / / / / / THROUGH / / / / / /
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY): I. M. Referring/Prescribing 12345677
20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES: ADMITTED / DISCHARGED
21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES [ ] NO [ ] CHARGES
23. A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR DX CODE
    1. V41.2
    2.
    3.
    4.
    B. EPSDT YES [ ] NO [X]
    FAMILY PLANNING YES [ ] NO [X]
    PRIOR AUTHORIZATION NO.

24 A. DATE OF SERVICE FROM / TO	B.* PLACE OF SERVICE	C. PROCEDURE CODE (IDENTIFY)	FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	G.* TOS	H. LEAVE BLANK
02/20/88	3	92553	Pure tone air & bone	1	XX XX	1.0	W	
02/20/88	3	92567	Tympanometry	1	XX XX	1.0	W	
			I. M. Performing					
			12345678					
								Patient Spenddown $

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF)
    DATE MM/DD/YY I.M. PROVIDER
26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK): YES [ ] NO [ ]
27. TOTAL CHARGE: XX XX
28. AMOUNT PAID: XX XX
29. BALANCE DUE: XX.XX
30. YOUR SOCIAL SECURITY NO.
31. PHYSICIAN'S, SUPPLIER'S, AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.:
    I.M. Billing
    1 W Williams
    Anytown WI 53725
    I.D. NO. 87654321
32. YOUR PATIENT'S ACCOUNT NO.: 1234JED
33. YOUR EMPLOYER I.D. NO. / / / / / / / / / / / /

*PLACE OF SERVICE AND TYPE OF SERVICE (TOS) CODES ON THE BACK
REMARKS

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6/83

Form HCFA-1500 (C-2) (1-84) Form OWCP-1500
Form CHAMPUS-501 Form RRB-1500